Montgomery County COBRA Select Plan Enrollment Form for 2004

PLEASE DO NOT STAPLE OR FOLD THIS FORM

MARKING INSTRUCTIONS

- **Use a No. 2 pencil only.**
- **Do not use ink, ballpoint, or felt tip pens.**
- **Make solid marks that fill the response completely.**
- **Erase cleanly any marks you wish to change.**
- **Make no stray marks on this form.**

CORRECT: ● **INCORRECT:** ✓ ✗ ⊖ ⊖

STATUS

◯ COBRA

Your Social Security No.

Name:
Address:

Part A PERSONAL DATA

CURRENT COVERAGE:

Your current coverage is listed below. Please note that if you do not complete the Flexible Spending Account section on the back of this form you may not participate in the Health/Dependent Care Reimbursement Accounts for 2004.

Medical:

Dental:

Vision:

Part B ELIGIBLE DEPENDENTS:

	Dependent's Name	Date of Birth	Gender	Relationship	Social Security #
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Add or delete dependents on separate form.

Part C MEDICAL PLAN - Participant must select Primary Care Physician (PCP) directly with Plan.

(Choose one plan)

◯ Kaiser-Permanente
◯ Optimum Choice (requires enrollment form for PCP)
◯ CareFirst BCBS POS (requires enrollment form for PCP)
◯ CareFirst BCBS POS Out of Area (for eligible participants only)
◯ No Medical Coverage

(Choose one coverage level)

◯ Single
◯ Employee plus one
◯ Family

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Part D DENTAL PLAN (Enrollment form required for New Enrollees in DHMO)

(Choose one Plan)

- ◯ CIGNA Dental PPO (Traditional Dental Plan)
- ◯ CIGNA Dental Care (DHMO)
- ◯ No Dental Coverage

(Choose one level of Coverage)

- ◯ Single
- ◯ Employee plus one
- ◯ Family

(If no dental coverage was elected, there is a two year waiting period for re-entry.)

Part E VISION PLAN

(Choose one Plan)

- ◯ Vision Plan
- ◯ No Vision Coverage

(Choose one level of Coverage)

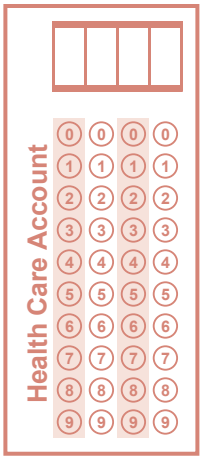
- ◯ Single
- ◯ Employee plus one
- ◯ Family

(If no vision coverage was elected, there is a two year waiting period for re-entry.)

Part F FLEXIBLE SPENDING ACCOUNTS

I understand that any funds for services incurred in 2004 not requested by March 31, 2005 will be forfeited. I choose to set aside the following annual amounts in the flexible spending accounts.

Maximum annual amount for Health Care is **$2,500** for reimbursement of eligible out of pocket health care expenses for you or any person who qualifies as your dependent for federal income tax purposes.



**** MUST BE COMPLETED TO PARTICIPATE FOR 2004**

**** WRITE IN ANNUAL DOLLAR AMOUNT**

**** MUST BE IN WHOLE NUMBERS**

Part G SIGNATURE (Must be signed for elections to become effective)

I have read the enclosed enrollment materials, as well as the Summary Plan Description for the Select Plan. I have also read the information available on the individual benefit plans under the Select Plan. This enrollment form indicates my benefit elections for calendar year 2004 and authorizes Montgomery County to make the necessary deductions to my pay based on my elections. If I have elected no medical coverage under the Select Plan, I certify that I have medical coverage that is at least equivalent to the benefit levels of the medical plans made available by the County, through some other means. In order to protect the tax exempt status for certain benefits under the Select Plan, I understand that these elections are in effect for the entire 2004 calendar year and can only be changed during the year if I have a *Change in Status,* as allowed by Section 125 of the Internal Revenue Code. I also understand that the County has the right to adjust my benefit elections in order to comply with requirements of the Internal Revenue Code. I authorize the release of information contained on this enrollment form to entities such as benefit providers, to the extent needed to properly administer the benefits I have elected.

I understand that enrollment in benefits to which I or my dependents are not entitled is considered fraud. In all cases, I am responsible for the accuracy of my benefit elections and coverage levels. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my enrollment form, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I may be required to repay any claims which have been paid inappropriately, and I may face charges or dismissal from County service.

I understand that the County expects to continue the Select Plan, but it is the County's position that there is no implied contract to do so. I also understand that the County reserves the right at any time and for any lawful reason to amend the Select Plan, subject to collective bargaining agreements. Further, I understand that the Select Plan may also be amended by the County at any time, either prospectively or retroactively, to conform with the Internal Revenue Code.

Your Signature: _____ Date: _____

All forms must be signed and received in the Office of Human Resources, EOB 7th floor, 101 Monroe Street, Rockville, MD 20850, no later than **5:00 p.m., Wednesday, November 12, 2003**.